The Madeira School
Permission for Prescription & Over-the-Counter Medications

This form must accompany all medication

Parent signature required for all medications. Physician signature required for all prescription medication.*

Student Name: _____ Date of Birth: _____

Parent Name: _____

Medication Name: _____

Prescribed Dosage: _____ Medication Strength: _____

Frequency/Time of Administration: □Morning □ Noon □ Evening □ Bedtime □ Other: _____

□ Mandatory □ Optional Comments: _____

Start Date: _____ End date (If Applicable): _____

Medication Name: _____

Prescribed Dosage: _____ Medication Strength: _____

Frequency/Time of Administration: □ Morning □ Noon □ Evening □ Bedtime □ Other: _____

□ Mandatory □ Optional Comments: _____

Start Date: _____ End date (If Applicable): _____

Discontinued Medication Name:

Prescribed Dosage: _____ Medication Strength:_____

Frequency/Time of Administration: □ Morning □ Noon □ Evening □ Bedtime

End date:

Special Instructions:

I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. ***Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent authorization must be submitted.***

Parent Signature: _____ Date: _____

Physician Name: _____ Phone/Email: _____

Physician Signature: _____ Date: _____

Madeira Health & Wellness Center Email: healthcenter@madeira.org Phone: 703-556-8243 Fax: 703-893-8102